

## APPLICANT INFORMATION

Primary Phone \_\_\_\_\_ Secondary Phone \_\_\_\_\_

1. Most recent federal tax form (1040 Tax Return) is preferred, or;
2. Income or wage statements (Examples include pay statements, social security, unemployment, public assistance, or other statements verifying money received by the family). Include at least three consecutive with this application. \*Note: If one or more family members are currently employed in seasonal employment, last year's tax return is required rather than monthly income.

**Total Number of Members in Household:** \_\_\_\_\_

Type of Income	Annual Amount
Gross wages	
Self-Employment	
Social Security, SSI or SSDI	
Pensions	
Public Assistance	
Unemployment/ Worker's Compensation	
<b>TOTAL</b>	

<b>2023 Federal Poverty Guidelines</b>			
Household Size	200%	300%	400%
<b>1</b>	\$29,160	\$43,740	\$58,320
<b>2</b>	\$39,440	\$59,160	\$78,880
<b>3</b>	\$49,720	\$74,580	\$99,440
<b>4</b>	\$60,000	\$90,000	\$120,000
<b>5</b>	\$70,280	\$105,420	\$140,560
<b>6</b>	\$80,560	\$120,840	\$161,120
<b>7</b>	\$90,840	\$136,260	\$181,680
<b>8</b>	\$101,120	\$151,680	\$202,240
More than 8 add the below figure for each additional person			
	\$10,280	\$15,420	\$20,560
% of Poverty Level	=<200%	201% - 300%	301% - 400%
<b>% of financial contribution provided by DHS</b>			
	100%	75%	50%

DHS provides financial assistance for hearing aids and initial ear molds only. Pre-approval is required, and payment is made directly to the facility. All other fees are the responsibility of the consumer. Percent of cost covered is determined by household size and income on a sliding fee scale according to the table above.

Upon approval of this application, I agree to the following:

- a) To be responsible for the daily care, maintenance, batteries, and replacement ear mold(s).
- b) To accept the terms of payment for any audiological services not covered by the program (fitting/dispensing, replacement ear mold(s), follow-up visits).
- c) Make payment directly to the audiologist for any applicable balance not covered by the financial contribution provided by the program.

I affirm that the information provided is complete and correct to the best of my knowledge.

\_\_\_\_\_  
Applicant Signature if 18

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

Submit **application**, **income documentation**, and **audiologist form** to:

Hailey Bowers  
Division of Rehabilitation Services  
811 E 10<sup>th</sup> Street Dept. 21  
Sioux Falls, South Dakota 57103  
Fax: 605-367-5327  
Hailey.Bowers@state.sd.us

## Hearing Aid Assistance Program Audiologist Form

*This section must be completed by the facility or audiologist dispensing the hearing aid(s)*

### APPLICANT INFORMATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### PROVIDER INFORMATION

Facility name: \_\_\_\_\_

Provider name: \_\_\_\_\_

Provider NPI (National Provider Identification) #: \_\_\_\_\_ State License #: \_\_\_\_\_

Phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_

### MEDICAL EVALUATION

As required by the FDA, a prospective hearing aid user must provide a written statement from a licensed physician that the prospective user has been medically evaluated and is a candidate for a hearing aid(s). A hearing evaluation must occur within 6 months prior to the date of purchase of the hearing aid(s). If 18 years of age or older, the prospective user may waive this requirement provided the prospective user signs a waiver statement. Children (age less than 18 years) are not eligible for a waiver.

I (audiologist name) \_\_\_\_\_ will obtain the physician's medical clearance necessary for the hearing aid(s) fitting prior to the fitting.

### HEARING EVALUATION

Date of evaluation: \_\_\_\_\_

Type of loss: (check)

Sensorineural R____ L____	Conductive R____ L____	Mixed R____ L____	Auditory Neuropathy Spectrum Disorder R____ L____
------------------------------	---------------------------	----------------------	--

Degree of hearing loss

Mild Hearing Loss: _____ (20 TO 40dB HL)	Moderate Hearing Loss: _____ (40 to 60 dB HL)
Severe Hearing Loss: _____ (60 to 80 dB HL)	Profound hearing loss (including deafness): _____ (+80 dB HL)

Diagnosis – Include an explanation of barriers resulting from the diagnosis as it relates to this equipment request

--

How long is this expected to last? Months\_\_\_\_\_ Indefinitely\_\_\_\_\_ Permanently\_\_\_\_\_

### HEARING AID INFORMATION

Has consumer used a hearing aid in the past? Yes\_\_\_\_ No\_\_\_\_

Approximate age of old hearing aid: \_\_\_\_\_

### EQUIPMENT

Manufacturer name: \_\_\_\_\_ Style/model: \_\_\_\_\_

Hearing aid for: Right Ear\_\_\_\_ Left ear\_\_\_\_ Binaural\_\_\_\_

Usual and Customary Cost of Equipment

Right ear	Left ear	Binaural
-----------	----------	----------

Usual and Customary Cost of Initial Ear Mold

Right ear	Left ear	Binaural
-----------	----------	----------

☐ I confirm that I will be doing Real Ear Verification

After evaluating this patient, I certify the need for the dispensing of a hearing aid(s)

Audiologist signature: \_\_\_\_\_ Date: \_\_\_\_\_

Upon application approval, the Department of Human Services will provide an authorization with the authorized dollar amount the applicant qualifies for to the provider.

### FINANCIAL CONTRIBUTION

- The South Dakota Hearing Aid Assistance Program is the payer of last resort after private health insurance or other third-party resources.
- The program only covers the cost of the hearing aids and initial ear molds. It is the responsibility of the provider to separate out any other applicable costs, including fitting and dispensing fees, which will be the responsibility of the consumer.
- Payment will be made directly to the provider. Prior authorization is required.
- Any applicable copayments are the responsibility of the consumer.